

# INDEPENDENT REVIEWERS OF TEXAS, INC.

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## Notice of Independent Review Decision

**[Date notice sent to all parties]:**

**8/18/2015**

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:** PT 2 x wk x 8 wk rt shoulder

**A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:**

Board Certified Orthopedic Surgeon

**REVIEW OUTCOME:**

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

☒ Upheld (Agree)

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

## **PATIENT CLINICAL HISTORY [SUMMARY]:**

The patient is a female who reported injuries to her neck and right shoulder as a result of an awkward fall on xx/xx/xx when her clothes became stuck in a door and her shoe. The MRI of the right shoulder dated XXXX revealed a small to moderate subacromial enthesophyte as well as a mild thickening at the coracoacromial ligament. Mild subacromial and subdeltoid bursitis was identified with a small fluid collection at the bursa. Mild tendinosis was identified at the distal supraspinatus tendon. A type 2 SLAP tear was identified as well. The clinical note dated XXXX indicates the patient utilizing Celebrex for ongoing pain relief. Upon exam, tenderness was identified at the supraspinatus, the rhomboid, and the levator scapulae. The patient was able to demonstrate 145 degrees of right shoulder flexion, 140 degrees of abduction, 90 degrees of external rotation, and 95 degrees of adduction with 40 degrees of internal rotation. The note indicates the patient having a positive Hawkins' and Jobe's sign. Radiating pain was identified from the shoulder into the right upper extremity. The clinical note dated XXXXX indicates the patient continuing with complaints of right shoulder pain with associated numbness and tingling in the right arm and hand. The patient rated the pain as 8/10, primarily at the upper trapezius and scapular region. Pain was

exacerbated with prolonged sitting and sleeping. 4+/5 strength was identified at the mid and lower trapezius and 4/5 strength was identified with external rotation. The medical records review dated XXXX indicates the patient having completed 12 physical therapy sessions between XXXX and XXXX.

The utilization review dated XXXX resulted in a denial for additional physical therapy as no exceptional factors were identified in the clinical notes.

**ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:**

The documentation indicates the patient complaining of ongoing right shoulder pain with associated range of motion deficits. There is an indication the patient had previously undergone 12 physical therapy sessions to date. Additional physical therapy would be indicated provided the patient meets specific criteria to include significant improvement identified through the initial course of treatment as well as ongoing functional deficits and the patient has been identified as having exceptional factors. No information was submitted regarding the patient's objective functional improvement through the initial course of therapeutic interventions. Additionally, no information was submitted regarding the patient's ongoing exceptional factors that would indicate the need for ongoing therapeutic interventions. Given these factors, the request is not indicated as medically necessary.

**A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:**

☒ **MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**

☒ **ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**

Physical therapy

ODG Physical Therapy Guidelines –

Allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home PT. Also see other general guidelines that apply to all conditions under Physical Therapy in the ODG Preface.

Superior glenoid labrum lesion (ICD9 840.7)

Medical treatment: 10 visits over 8 weeks